MEDICAL WASTE MANAGEMENT PLAN

Date _____

Reason for submittal of this plan:

☐ New Facility
☐ Relocation of Permitted Facility
☐ Transfer of Ownership
☐ Changes to previously submitted Medical Waste Management Plan

Facility Generating Medical Waste _____

Facility Site Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

Telephone (_____) _____ Facility No. _____

Fax (_____) _____

Contact Person responsible for implementation of plan regarding medical waste at the facility:

Name _____ Title _____

Email _____ Telephone (_____)_____

Type of Medical Waste Facility:

☐ **Small Quantity Generator (SQG):** Your facility generates less than 200 pounds of medical waste per month.

☐ **Small Quantity Generator With On-Site Treatment:** Medical waste is TREATED on-site.

☐ **Limited Quantity Hauling Exemption (LQHE):** Less than 20 pounds of medical waste per week is generated or transported at one time to a treatment facility, transfer station, or other health care facility (LQG) or home nursing parent organization for consolidation prior to collection and treatment.

☐ **Large Quantity Generator (LQG):** Your facility generates 200 pounds or more of medical waste in any month of a 12–month period.

☐ **Large Quantity Generator with On-Site Treatment:** Medical waste is TREATED on-site.

☐ **Common Storage Facility Permit:** Any designated accumulation area which is on-site and is used by small quantity generators otherwise operating independently, for example, a medical arts building.

☐ **Home Health Agency:** Must register as SQG or LQG **and** apply for LQHE.

Date _____ Facility No. _____

If your facility generates 20 pounds or less of medical waste per week, do you want to apply for a Limited Quantity Hauling Exemption (LQHE)? This allows your facility to transport less than 20 pounds of medical waste at one time to a treatment facility, transfer station, or other health care facility (LQG) or home nursing parent organization for consolidation prior to collection and treatment without hiring a registered medical waste hauler.

☐ Yes **(If yes, complete the attached LQHE form)** ☐ No

How does your facility dispose of medical waste?

☐ A registered hauler transports the waste to a permitted off-site treatment facility

Registered hauler name _____

Address _____

City _____ State _____ Zip _____

☐ Autoclave (on-site treatment)

Alternative treatment technology (on-site treatment):

☐ Isolyzer

☐ Mail back Sharps Disposal Company

☐ Other State Approved method

Types of wastes generated:

☐ Laboratory wastes - specimen or microbiologic cultures, stocks of infectious agents, live and attenuated vaccines, and culture mediums.

☐ Blood or body fluids - liquid blood elements or other regulated body fluids, or articles contaminated with blood or body fluids.

☐ Sharps - syringes, needles, blades, broken glass.

☐ Contaminated animals - animal carcasses, body parts, bedding materials.

☐ Surgical specimens - human or animal parts or tissues removed surgically or by autopsy.

☐ Isolation waste - waste contaminated with excretion, exudate, or secretions from humans or animals who are isolated due to highly communicable diseases. (*Centers for Disease Control, Biosafety Level 4)**

☐ Wastes contaminated with fixatives or chemotherapeutic agents.

☐ Other (Specify):

☐ Pharmaceutical wastes - California only hazardous pharmaceutical waste.

Provide an estimated quantity of medical waste generated monthly: _____ pounds.

*Biosafety Level 4 viruses and diseases are: Congo-Crimean hemorrhagic fever, Tick-borne encephalitis virus complex (*Absettarov, Hanzalova, Hypr, Kumlinge, Kyasanur Forest disease, Omsk hemorrhagic fever, and Russian Spring-Summer encephalitis*), Marburg disease, Ebola, Junin virus, Lassa fever virus, Machupo virus.

What emergency action plan does your facility have in the event of an emergency (*e.g. treatment system breaks down, hauler unable to pick up waste, spill, natural disaster, etc.*)

_____

_____

_____

_____

_____

_____

_____

_____

Note: Any future changes to the information provided must be submitted to the Division of Environmental Health Services/LEA within 30 days, pursuant to the Medical Waste Management Act, §117940(d) Small Quantity Generators, and §117970(d) Large Quantity Generators.

I hereby certify to the best of my knowledge and belief that the statements made herein are complete and accurate.

Name _____ Title _____

Signature _____ Date _____

Medical Wastes Accepted From Other Facilities

Date _____ **Facility No.** _____

Medical Wastes accepted for: ☐ Consolidation ☐ Treatment

Facility Name _____

Address _____

City _____ State _____ Zip _____

Responsible person _____

Telephone (_____) _____ Facility No. _____

Medical Wastes accepted for: ☐ Consolidation ☐ Treatment

Facility Name _____

Address _____

City _____ State _____ Zip _____

Responsible person _____

Telephone (_____) _____ Facility No. _____

Medical Wastes accepted for: ☐ Consolidation ☐ Treatment

Facility Name _____

Address _____

City _____ State _____ Zip _____

Responsible person _____

Telephone (_____) _____ Facility No. _____